North Carolina Department of Health and Human Services
Purchase of Medical Care Services

PHARMACY CLAIM

Mail Claim to: N.C. Department of Health and Human Services
Claims Processing Branch
1904 Mail Service Center
Raleigh, NC 27699-1904

CLAIMS MUST BE RECEIVED WITHIN ONE YEAR AFTER DISPENSING DATE IN ORDER TO BE PAID

1a. **NC Medicaid Pharmacy Provider No. or NPI No.:** _____

1b. Tax ID No.: _____

2a. Pharmacy: _____

2b. Address: _____
Street

_____
City State Zip

3. Telephone: ( )_____ 4. Billing Date: _____

5. Prescribing Physician's DEA No.: _____

6. Patient's Name per Eligibility: _____ D.O.B.:_____
Last Name First Name

7. Patient's Address: _____
City State Zip

8. Program Name: _____

9. **Program Case No.:** _____ Authorization No.: _____

10. Other Third Party Coverage: _____

Claims Address: _____

Telephone No.: _____ Policy No.:_____

11. LEGEND PRESCRIPTION DRUGS (See definition in Part 11 instructions on reverse of form.)

(A) PRESCRIPTION NUMBER	(B) NAME OF DRUG	(C) NDC NO.	(D) STRENGTH	(E) QUANTITY	(F) DATE FILLED	(G) EST DAYS' SUPPLY	(H) COST	(I) B/G*	(J) INS. PYMT., IF ANY	LEAVE BLANK

*Please indicate B for Brand or G for Generic.

12. PHARMACY/OTC ITEMS (See definition in Part 12 instructions on reverse of form.)
Durable medical equipment, medical supplies, and formula with HCPCS codes must be billed on the HCFA 1500 claim form.

(A) PRESCRIPTION OR REFERENCE NO.	(B) NAME OF DRUG/ITEM	(D) STRENGTH	(E) QUANTITY	(F) DATE SOLD	(G) EST. DAYS' SUPPLY	(H) CHARGE	LEAVE BLANK

I certify that this information is accurate, and I agree to the Terms and Conditions on the reverse.

X_____
Dispensing Pharmacist's Signature

13. (a) Total cost of the drugs in Section 11: $_____

(b) Dispensing fee: Brand _____X_____Rx: $_____

Dispensing fee: Generic _____X_____Rx: $_____

[See Instruction 13(b) on reverse of form.]

(c) Total charge for pharmacy OTC items in Section 12: $_____
(State of North Carolina is tax exempt – do not include tax)

(d) Grand total $_____

DHHS 3058 (Revised 1/07)
Purchase of Medical Care Services (Review 8/08)

Distribution:
White, Claims Processing Branch;
Yellow, Vendor

Purpose: To provide pharmacists with a standard method for billing the following programs:

Children's Special Health Services
Kidney Program
Sickle Cell Program
Migrant Health Program
Adult Cystic Fibrosis Program

Preparation: For each client, submit one claim monthly that contains all charges for a single calendar month. In items 1-10, enter the information requested.

In spaces 11(A) through 11(I), enter the information about prescription drugs as described below (NOTE: A prescription drug is defined as one that bears the statement "CAUTION: Federal Law Prohibits Dispensing Without Prescription" on the label of the manufacturer's original package. Assigning a prescription number to a non-prescription drug does not make it a prescription drug, even if a prescription has been issued. Exception: All pharmacist-compounded prescription orders are considered to be prescription drugs.):

11(A) The prescription (or file) number assigned by the individual pharmacy.
11(B) The brand name (proprietary name) of the drug actually dispensed, or the generic name (non-proprietary name) of the non-branded drug actually dispensed.
11(C) The National Drug Code (NDC) number assigned to the product actually dispensed.
11(D) The concentration of drug per unit volume or per unit weight.
11(E) The quantity of drug dispensed, e.g., number of tabs, caps, ml, cc, oz.
11(F) The date the prescription order was actually filled.
11(G) The estimated number of days the dispensed quantity of drug should last if used in accordance with the prescriber's directions.
11(H) The cost of the drug. The amount you enter here will be compared to the maximum cost allowed by the Medicaid Program. If you intend to bill your usual charge to the public, you must deduct the dispensing fee here. The dispensing fee is billed in item 13(b). [NOTE: drugs covered by the Maximum Allowable Cost Program (MAC) will be reimbursed at MAC rates unless (1) a prescriber override has been made, and (2) the letters "OA" have been entered in the last two digits of the NDC number to indicate the override.]
11(I) Please indicate B for Brand or G for Generic drug.
11(J) The amount of an insurance payment on the drug.

In spaces 12(A) through 12(H), enter the information about pharmacy/OTC items as described below:

12(A) The prescription (or file) number assigned, if any, assigned by the individual pharmacy.
12(B) The brand name (proprietary name) of the drug or item actually dispensed, or the generic name (non-proprietary name) of the non-branded drug or item actually dispensed.
12(D) The concentration of drug or item per unit volume or per unit weight.
12(E) The quantity of drug dispensed, e.g., number of tabs, caps, ml, cc, oz., or items.
12(F) The date the order was actually filled.
12(G) The estimated number of days the dispensed quantity of drug or item should last if used in accordance with the prescriber's directions.
12(H) The dispensing pharmacist's usual charge for the drug or item.

Item 13
(a) Enter total cost of the drugs in Section 11.
(b) In the first blank, enter the lower of: 1) the allowable Medicaid dispensing fee in effect at the time the prescription drug is dispensed, or 2) the usual and customary dispensing fee charged to the general public for the same service. In the second blank, enter the total number of prescriptions dispensed in Section 11. Multiply, and enter the result in the third blank. Do this for both brand name and generic drugs.
(c) Enter total usual charge for pharmacy OTC items in Section 12.
(d) Enter total of a, b, and c.

For Assistance in Completing this Form: Telephone (919) 855-3702

Mailing: Mail white copy to: Claims Processing Branch, Department of Health and Human Services, 1904 Mail Service Center, Raleigh, NC 27699-1904. Keep yellow copy for pharmacy records.

Disposition: Copies of this form retained by state agencies may be destroyed in accordance with the *Records Disposition Schedule* published by the N.C. Division of Archives and History.

Copies of this form retained by county agencies may be destroyed in accordance with Standard 2, Budget and Fiscal Records, of the County and District Health Department *Records Disposition Schedule* published by the N.C. Division of Archives and History.

Additional forms may be ordered from: Purchase of Medical Care Services, Department of Health and Human Services, 1904 Mail Service Center, Raleigh, NC 27699-1904.

TERMS AND CONDITIONS

1. I understand that complete billing information is available from the Purchase of Medical Care Services Section upon request and that this information is mailed annually to all participating pharmacies.
2. I understand that payment is at the Medicaid rate of reimbursement for prescription drugs and other items (the rate in effect at the time a claim is received) and that this includes reimbursement for MAC drugs.
3. I understand that payment is available only for service which has been authorized by a program and that claims must be received by the Department within one year after the dispensing date in order to be paid.
4. I understand that payment is available only for services not covered by another third party payer and that Medicaid must be billed for any service that can be paid by Medicaid.
5. I understand that payment is subject to the availability of funds.

WEBSITE: http://www.dhhs.state.nc.us/control1/pomcs/pomcs.htm

CLAIM NOT VALID UNLESS SIGNED ON THE REVERSE BY DISPENSING PHARMACIST.

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